HOSPITAL ACUTE INPATIENT SERVICES PAYMENT SYSTEM

*payment***basics**

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This document does not reflect proposed legislation or regulatory actions.

MEDPAC

601 New Jersey Ave., NW
Suite 9000
Washington, DC 20001
ph: 202-220-3700
fax: 202-220-3759
www.medpac.gov

Medicare beneficiaries enrolled in the traditional fee-for-service program receive care in about 3,500 facilities that contract with Medicare to provide acute inpatient care and agree to accept the program's predetermined payment rates as payment in full.[1] Payments made under the acute inpatient prospective payment system (IPPS) totaled $100 billion and accounted for about 35 percent of Medicare spending in 2005. These payments provide about 20 percent of hospitals' overall revenues. Acute inpatient stays were the first to be converted to prospectively determined payment, beginning in fiscal year 1984.

Medicare's inpatient hospital benefit covers beneficiaries for 90 days of care per episode of illness, with a 60-day lifetime reserve. Illness episodes begin when beneficiaries are admitted and end after they have been out of the hospital or a skilled nursing facility for 60 consecutive days. In 2006, beneficiaries are liable for a deductible of $952 for the first hospital stay in an episode, and daily copayments—currently $238—are imposed beginning on the 61st day.

As outlined in Figure 1, the IPPS pays per-discharge rates that begin with two national base payment rates—covering operating and capital expenses—which are then adjusted to account for two broad factors that affect hospitals' costs of furnishing care:

- the patient's condition and related treatment strategy, and
- market conditions in the facility's location.

Medicare assigns discharges to diagnosis related groups (DRGs), which group patients with similar clinical problems that are expected to require similar amounts of hospital resources. Each DRG has a relative weight that reflects the expected relative costliness of inpatient treatment for patients in that group. The payment rates for DRGs in each local market are determined by adjusting the base payment rates to reflect the input-price level in the local market, and then multiplying by the relative weight for each DRG. Then the operating and capital payment rates are increased for facilities that operate an approved resident training program or that treat a disproportionate share of low-income patients. Rates are reduced for certain transfer cases, and outlier payments are added for cases that are extraordinarily costly.

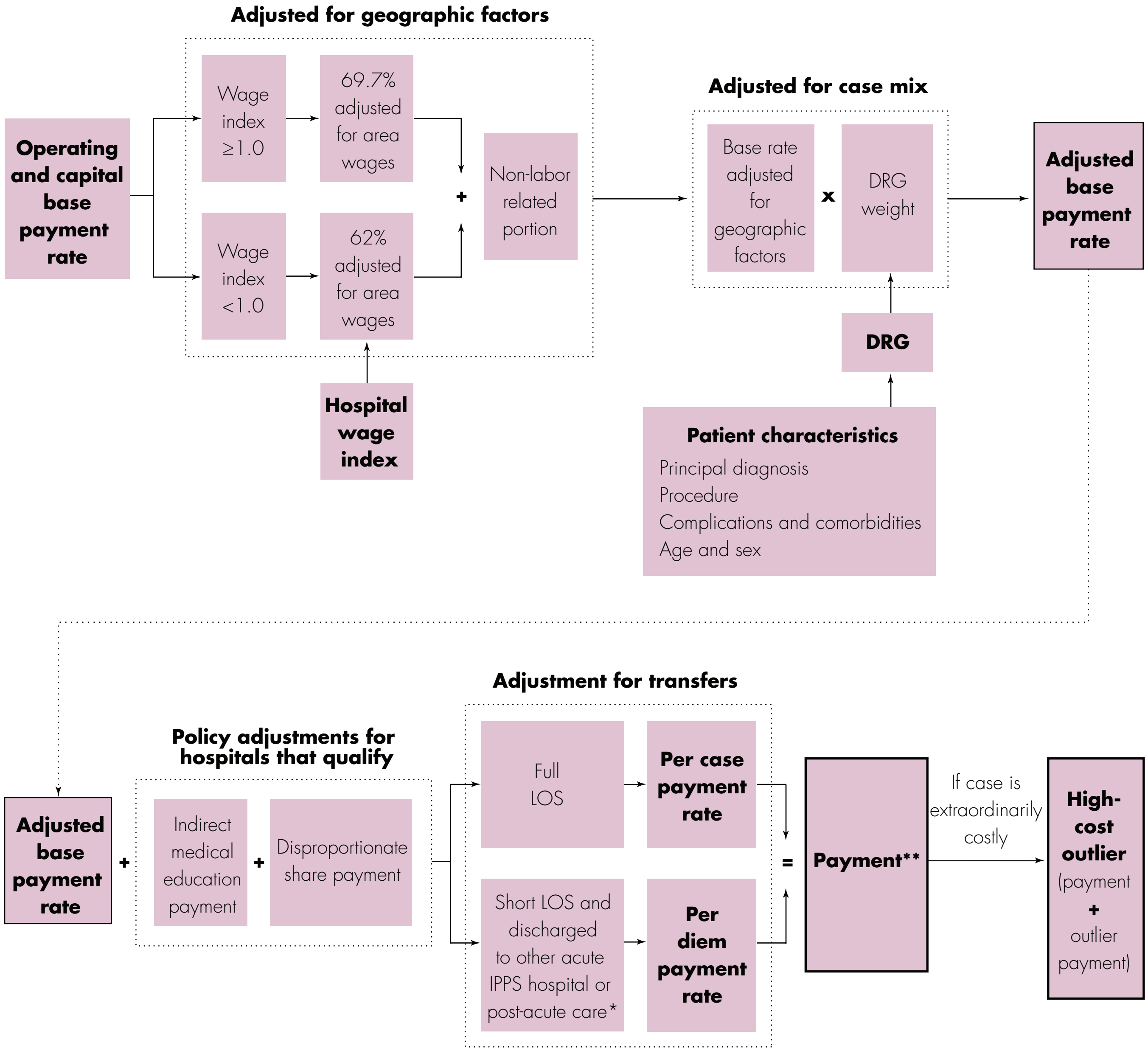
The IPPS payment rates are intended to cover the costs that reasonably efficient providers would incur in furnishing high quality care, thereby rewarding providers whose costs fall below the payment rates and penalizing those with costs above the payment rates.

Defining the inpatient acute care products Medicare buys

Under the IPPS, Medicare sets per-discharge payment rates for 536 DRGs, which are based on patients' clinical conditions and treatment strategies.[2] Clinical conditions are defined by patients' discharge diagnoses, including the principal diagnosis—the main problem requiring inpatient care—and up to eight secondary diagnoses indicating other conditions that were present at admission (comorbidities) or developed during the hospital stay (complications). The treatment strategy—surgical or medical—is defined by the presence or absence of up to six procedures performed during the stay.[3]

The Centers for Medicare & Medicaid Services (CMS) annually reviews the DRG definitions to ensure that each group continues to include cases with clinically similar conditions requiring comparable

Figure 1 Acute inpatient prospective payment system



Note: DRG (diagnosis related group), LOS (length of stay), IPPS (inpatient prospective payment system).
* Transfer policy for cases discharged to post-acute care settings applies for cases in 182 selected DRGs.
** Additional payment made for certain rural hospitals.

amounts of inpatient resources. When the review shows that subsets of clinically similar cases within a DRG consume significantly different amounts of resources, CMS often reassigns them to a different DRG with comparable resource use or creates a new DRG.[4]

Facing fixed payment rates, providers have financial incentives to reduce their inpatient costs by moving some services to another setting. Medicare has adopted policies to counter these incentives. Thus, related outpatient department services delivered in the three days before admission are included in the payment for the inpatient stay and may not be separately billed (the 72-hour rule). Similarly, payment is reduced when patients have a short length of stay and are transferred to another acute care hospital or, in many DRGs, when patients are discharged to post-acute care settings.

Setting the payment rates

Medicare's payments are derived through a series of adjustments applied to separate operating and capital base payment rates. The base rates are updated annually, and absent other policy changes, the update raises all payment rates proportionately.

The base payment amounts Medicare sets per discharge base rates (known as standardized payment amounts) for the operating and capital costs that efficient facilities would be expected to incur in furnishing covered inpatient services.[5] Operating payments cover labor and supply costs; capital payments cover costs for depreciation, interest, rent, and property-related insurance and taxes. For fiscal year 2007, the operating base rate is $4,878.[6] The capital rate is $427.[7]

The DRG relative weights Medicare assigns a weight to each DRG reflecting the average relative costliness of cases in that group compared with that for the average Medicare case. The same DRG weights are used to set operating and capital payment rates. CMS recalibrates the DRG weights annually, without affecting overall payments, based on standardized costs for all PPS cases in each DRG.[8]

Hospitals with cases treated using certain technologies receive add-on payments for new technologies. CMS evaluates applications by technology firms and others for add-on payments based on criteria of newness, clinical benefit, and cost. New technology payments are additional to the DRG payment and thus are not budget neutral.

Adjustment for market conditions

Medicare's base operating and capital rates are adjusted by an area wage index to reflect the expected differences in local market prices for labor.[9] The wage index is intended to measure differences in hospital wage rates among labor markets; it compares the average hourly wage for hospital workers in each metropolitan statistical area or statewide rural area to the nationwide average.[10] The wage index is revised each year based on wage data reported by the IPPS hospitals.

The wage index is applied to the labor-related portion of the base rate (usually called the "labor share"), which reflects an estimate of the portion of costs affected by local wage rates and fringe benefits. CMS's current estimate of the operating labor share is 69.7 percent. The Congress has legislated an operating labor share of 62 percent for areas with a wage index less than or equal to 1.0. CMS's estimate of the labor share is applied to hospitals with a wage index above 1.0.

The wage index applied to the capital base rate is raised to a fractional power, which narrows the geographic variation in wage index values among market areas. A single labor share is used for all hospitals. The capital rate is increased by 3 percent for hospitals in MSAs with a population of one million or more.[11]

Bad debts Medicare reimburses acute-care hospitals for 70 percent of bad debts resulting from beneficiaries' nonpayment of deductibles and copayments after providers have made reasonable efforts to collect the unpaid amounts.

Policy adjustments Certain hospitals receive additional operating and capital payments. Qualifying hospitals include those that operate resident training programs, treat a disproportionate share of low-income patients, or are located in a rural area and meet certain criteria. In addition, more than a thousand rural hospitals qualify as critical access hospitals and are paid on a cost basis (incurred costs plus 1 percent) instead of under the IPPS. The *Critical access* *hospitals payment system* document in our "Payment Basics" series provides more information on this topic.

Medical education payments Teaching hospitals receive add-on payments to reflect the additional (indirect) costs of patient care associated with resident training. Nearly 95 percent of teaching facilities are located in urban areas, although they serve Medicare beneficiaries living in both urban and rural areas.

The size of the indirect medical education (IME) adjustment depends on the hospital's teaching intensity. For operating payments, teaching intensity is measured by a hospital's number of residents per bed. For fiscal year 2007, the operating IME adjustment will drop to 5.35 percent for every 10 percent increase in the resident-to-bed ratio and then increase back to 5.5 percent for fiscal year 2008.

Because the capital IME adjustment is based on the measured effect of teaching intensity on hospitals' costs (the so-called "empirical level"), the add-ons are much smaller than those made for operating payments, where the rate is set substantially above the empirical level.

Medicare pays separately for the direct costs of operating approved training programs for medical, dental, or podiatric residents. These graduate medical education (GME) payments are based on hospital-specific costs per resident in a base year. The per-resident payment amounts are frozen for hospitals with amounts above 140 percent of the national average.

Disproportionate share payments
Hospitals that treat a disproportionate share (DSH) of low-income patients receive additional operating and capital payments thought to offset the financial effects of these patients. A hospital's low-income patient share is the sum of the proportion of its Medicare inpatient days provided to patients eligible for Supplemental Security Income benefits and the proportion of its total acute inpatient days furnished to Medicaid patients. Any hospital with a low-income share exceeding 15 percent is eligible to receive operating DSH payments based on a complex formula. However, the add-on rate is capped at 12 percent of base inpatient payments for most rural hospitals and urban facilities with fewer than 100 beds.[12]

As with the IME adjustment, the capital DSH add-ons are much smaller than the operating ones because the capital adjustment is based on the empirically estimated cost effect of treating low-income patients, while the operating adjustment is set substantially above the empirical level.

Special payments for rural hospitals
Medicare makes additional payments to certain rural hospitals, although some urban facilities also may qualify. The sole community hospital (SCH) program and a low-volume payment adjustment are intended to maintain access to needed health services for Medicare beneficiaries by assisting hospitals that are geographically isolated. Hospitals located at least 35 miles from the nearest like hospital (excluding CAHs) are eligible for the SCH program. These facilities receive the higher of payments under the IPPS or payments based on their costs in a base year updated to the current year and adjusted for changes in their case mix. Facilities that are more than 25 miles from the nearest like hospital and have fewer than 200 inpatient discharges from all payment sources receive a 25 percent add-on to their prospective rate.

The Medicare-dependent hospital (MDH) program is for small rural hospitals in which Medicare patients comprise at least 60 percent of their admissions or patient days. These hospitals receive IPPS payments plus half the difference between those payments and payments based on their updated base year costs.

Outlier payments Some cases are extraordinarily costly, producing losses that may be too large for hospitals to offset. To promote access to high-quality inpatient care for seriously ill beneficiaries, Medicare makes extra payments for these so-called outlier cases, in addition to the usual operating and capital DRG payments.

Outlier cases are identified by comparing their costs to a DRG-specific threshold that is the sum of the hospital's:

- DRG payment for the case (both operating and capital),
- any IME, DSH, and new technology payments, and
- a fixed loss amount.

CMS sets a national fixed loss amount ($24,475 for fiscal year 2007), which is adjusted to reflect input price levels in the hospital's local market. Outliers are financed by offsetting reductions in the operating base rate (5.1 percent) and the capital base rate (4.8 percent). CMS sets the national fixed loss amount at the level it estimates will result in outlier payments equaling the offset. Medicare pays 80 percent of hospitals' costs above their fixed loss thresholds.[13]

Transfer policy Medicare reduces DRG payments when patients:

- have a length of stay at least one day less than the geometric mean length of stay for the DRG,[14]
- and are transferred to another hospital covered by the acute inpatient PPS, or in 182 DRGs, are discharged to a post-acute care setting.

The post-acute settings covered by the transfer policy include long-term care hospitals, rehabilitation, psychiatric or skilled nursing facilities, and home health care if the patients receive clinically related care that begins within three days after the hospital stay.

Transferring facilities under this policy are paid a per diem rate. Generally, hospitals receive twice the per diem for the first day and the per diem for each additional day up to the full DRG rate.[15] An acute care hospital receiving a transferred patient is paid according to the appropriate DRG, which may or may not be the same as the DRG assigned in the preceding hospital stay.

Payment updates Both operating and capital payment rates are updated annually. Unless Congress intervenes, the operating update is set at the projected increase in CMS's market basket index (which measures the price increases of goods and services hospitals buy to produce patient care), while the Secretary determines the capital update. Payments to hospitals that fail to provide data on specified quality indicators are reduced by 2.0 percentage points. ■

1 Fee-for-service beneficiaries may also obtain acute inpatient care from critical access hospitals (CAHs), which are paid their incurred Medicare-allowable costs. The CAH program is described in a separate paper. Medicare pays the approved amount (based on either incurred costs or the IPPS rate) minus any beneficiary liability, such as a deductible or copayment; the provider then collects the remaining amount from the beneficiary or a supplemental insurer.

2 Although the federal DRG classification system includes 579 categories, 43 are not used for Medicare payment.

3 Age, sex, discharge destination, and even use of a specific drug are also occasionally used to distinguish groups of patients who are expected to use different amounts of resources.

4 For fiscal year 2007, CMS deleted 8 DRGs, added 20 new categories, and modified the definitions of 32 others as a preliminary refinement to better account for differences in severity of illness among patients.

5 Certain costs are excluded from the acute inpatient PPS and paid separately, such as the direct costs of operating graduate medical education programs and organ acquisition costs.

6 Hospitals in Puerto Rico receive a 75/25 blend of the federal base payment amount and a Puerto Rico-specific rate.

7 New hospitals are exempt from prospective payment for capital costs for two years. During this period, they are paid 85 percent of their Medicare-allowable capital costs.

8 Through fiscal year 2006, CMS based the DRG weights on charges rather than costs. Hospitals' costs are standardized to improve comparability. This involves adjusting costs to remove differences associated with variations in local market prices for inputs and those related to the size and intensity of hospitals' resident training activities, as well as the low-income patients hospitals treat.

9 A cost-of-living adjustment (COLA) is also applied to the base operating and capital rates in Hawaii and Alaska. The COLA is intended to reflect the higher costs of supplies and other nonlabor resources in these states. A hospital may request geographic reclassification to an adjacent market area for its wage index and capital geographic adjustment factor. To qualify, a hospital must demonstrate proximity (location within 15 miles of the border of the adjacent area for urban hospitals

and 35 miles for rural hospitals). It also must show that its hourly wages are above average for its market area (above 106 percent for rural hospitals and 108 percent for urban hospitals) and comparable to wages in the area to which it seeks reclassification (at least 82 percent of that area's average for rural hospitals and 84 percent for urban hospitals). Certain hospitals that did not meet the normal criteria for reclassification were reclassified for fiscal years 2005–2007 through a special one-time appeals process. Some hospitals also qualify for a higher wage index based on county commuting patterns.

10 For fiscal year 2007, CMS implemented an occupational mix adjustment to the hospital wage index for nursing-related personnel. This adjustment is designed to ensure that wage index values do not reflect the effects of differences in mix of workers (a greater share of RNs and smaller share of nurse aides in some areas, for example).

11 Eligible hospitals may qualify for capital exceptions payments if they meet project size, need and, for certain urban hospitals, excess capacity tests, or if they incur extraordinary capital expenditures in excess of $5 million.

12 The 12-percent cap does not apply to rural facilities with at least 500 beds or to rural referral centers. A 35 percent adjustment rate applies to hospitals that receive at least 30 percent of their inpatient revenue (excluding Medicare and Medicaid) from state and local government subsidies.

13 Costs for individual cases are estimated by reducing the hospital's covered charges for the case by its overall Medicare cost-to-charge ratio from its most recent tentatively settled cost report. Medicare pays 90 percent of costs above the outlier threshold for burn cases.

14 A geometric mean gives less weight to unusually long lengths of stay than an arithmetic mean, thus producing a lower estimate of the average length of stay and fewer cases affected by the transfer policy.

15 The per diem rate is the hospital's DRG payment rate divided by the geometric mean length of stay for the same DRG. Hospitals may also receive outlier payments calculated using a loss threshold prorated to reflect the length of stay.